



## Complete Summary

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### GUIDELINE TITLE

Atrial fibrillation.

### BIBLIOGRAPHIC SOURCE(S)

Institute for Clinical Systems Improvement (ICSI). Atrial fibrillation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2007 Feb. 64 p. [112 references]

### GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Atrial fibrillation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2004 Nov. 60 p.

### \*\* REGULATORY ALERT \*\*

### FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- [August 16, 2007, Coumadin \(Warfarin\)](#): Updates to the labeling for Coumadin to include pharmacogenomics information to explain that people's genetic makeup may influence how they respond to the drug.
- [December 8, 2006, Heparin Sodium Injection](#): Revisions to the WARNINGS section of the prescribing information for Heparin to inform clinicians of the possibility of delayed onset of heparin-induced thrombocytopenia (HIT), a serious antibody-mediated reaction resulting from irreversible aggregation of platelets.
- [October 6, 2006, Coumadin \(warfarin sodium\)](#): Revisions to the labeling for Coumadin to include a new patient Medication Guide as well as reorganization and highlighting of the current safety information to better inform providers and patients.

### COMPLETE SUMMARY CONTENT

\*\* REGULATORY ALERT \*\*

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INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT  
CATEGORIES  
IDENTIFYING INFORMATION AND AVAILABILITY  
DISCLAIMER

## SCOPE

### DISEASE/CONDITION(S)

- Atrial fibrillation (A Fib)
- Atrial flutter (A Flutter)

### GUIDELINE CATEGORY

Diagnosis  
Evaluation  
Management  
Prevention  
Risk Assessment  
Treatment

### CLINICAL SPECIALTY

Cardiology  
Emergency Medicine  
Family Practice  
Internal Medicine

### INTENDED USERS

Advanced Practice Nurses  
Allied Health Personnel  
Health Care Providers  
Health Plans  
Hospitals  
Managed Care Organizations  
Nurses  
Physician Assistants  
Physicians

### GUIDELINE OBJECTIVE(S)

- To increase the percentage of patients age 18 years and older who are accurately diagnosed with A Fib
- To improve the consistency of anticoagulation in patients with paroxysmal, persistent or permanent atrial fibrillation/atrial flutter (A Fib/Flutter)
- To improve rate control in patients with permanent A Fib

- To increase the percentage of patients with A Fib/Flutter who receive patient education

## TARGET POPULATION

Adults with first detected episode and recurrent (paroxysmal, persistent or permanent) atrial fibrillation (A Fib) and atrial flutter (A Flutter)

## INTERVENTIONS AND PRACTICES CONSIDERED

### Diagnosis

1. 12-lead electrocardiogram (ECG)
2. Assessment for hemodynamic stability
3. Echocardiography
4. Chest x-ray
5. Computed tomography (CT) of chest
6. Coronary/pulmonary angiography
7. Thyroid function tests
8. Cardiology or electrophysiology consult as needed
9. Evaluation for potentially reversible causes of atrial fibrillation (A Fib), comorbidities, risk factors for bleeding, risk factors for thromboembolism, and other special situations such as recent surgery, acute myocardial infarction, preexcitation, hypertrophic cardiomyopathy, pulmonary diseases, hyperthyroidism, or pregnancy

### Management/Treatment

1. Electrical (DC) cardioversion
2. Antiarrhythmic/chemical cardioversion
3. Patient education regarding A Fib disease process, symptoms, treatment options, risks, drug interactions
4. Rate control agents: atenolol (Tenormin); metoprolol (Lopressor); propranolol (Inderal); esmolol (Brevibloc); verapamil; diltiazem (Cardizem); digoxin (Lanoxin); digoxin in combination with calcium channel blocker or beta-blocker
5. Antiarrhythmic agents: quinidine; procainamide; disopyramide (Norpace), flecainide (Tambocor), propafenone (Rythmol), amiodarone (Cordarone), sotalol (Betapace), ibutilide (Corvert), dofetilide (Tikosyn)
6. Acute and/or chronic anticoagulation: warfarin and unfractionated heparin (UFH)
7. Coronary bypass or valve replacement/repair
8. Catheter based ablative therapies such as HIS-bundle ablation and permanent pacemaker implantation; atrial flutter ablation; and pulmonary vein isolation for atrial fibrillation suppression
9. Cardiac pacing, such as single- or dual-site atrial pacing and implantable cardioverter defibrillator
10. Surgical maze procedure
11. Monitoring for recurrence (self-monitoring and adjunctive monitoring)

## MAJOR OUTCOMES CONSIDERED

- Rates of cardioversion
- Symptom control
- Rate and rhythm control
- Rates of recurrence of atrial fibrillation (A Fib) or flutter
- Adverse effects of treatments
- Risk of thromboembolic complications or stroke or fatal bleeding

## METHODOLOGY

### METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

### NUMBER OF SOURCE DOCUMENTS

Not stated

### METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

### RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Key conclusions (as determined by the work group) are supported by a conclusion grading worksheet that summarizes the important studies pertaining to the conclusion. Individual studies are classed according to the system presented below, and are designated as positive, negative, or neutral to reflect the study quality.

Conclusion Grades:

Grade I: The evidence consists of results from studies of strong design for answering the question addressed. The results are both clinically important and consistent with minor exceptions at most. The results are free of any significant doubts about generalizability, bias, and flaws in research design. Studies with negative results have sufficiently large samples to have adequate statistical power.

Grade II: The evidence consists of results from studies of strong design for answering the question addressed, but there is some uncertainty attached to the conclusion because of inconsistencies among the results from the studies or because of minor doubts about generalizability, bias, research design flaws, or adequacy of sample size. Alternatively, the evidence consists solely of results from weaker designs for the question addressed, but the results have been confirmed in separate studies and are consistent with minor exceptions at most.

Grade III: The evidence consists of results from studies of strong design for answering the question addressed, but there is substantial uncertainty attached to the conclusion because of inconsistencies among the results of different studies or because of serious doubts about generalizability, bias, research design flaws, or adequacy of sample size. Alternatively, the evidence consists solely of results from a limited number of studies of weak design for answering the question addressed.

Grade Not Assignable: There is no evidence available that directly supports or refutes the conclusion.

#### Study Quality Designations:

The quality of the primary research reports and systematic reviews are designated in the following ways on the conclusion grading worksheets:

Positive: indicates that the report or review has clearly addressed issues of inclusion/exclusion, bias, generalizability, and data collection and analysis.

Negative: indicates that these issues (inclusion/exclusion, bias, generalizability, and data collection and analysis) have not been adequately addressed.

Neutral: indicates that the report or review is neither exceptionally strong nor exceptionally weak.

Not Applicable: indicates that the report is not a primary reference or a systematic review and therefore the quality has not been assessed.

#### Classes of Research Reports:

##### A. Primary Reports of New Data Collection:

###### Class A:

- Randomized, controlled trial

###### Class B:

- Cohort study

###### Class C:

- Nonrandomized trial with concurrent or historical controls
- Case-control study
- Study of sensitivity and specificity of a diagnostic test
- Population-based descriptive study

###### Class D:

- Cross-sectional study

- Case series
- Case report

B. Reports that Synthesize or Reflect upon Collections of Primary Reports:

Class M:

- Meta-analysis
- Systematic review
- Decision analysis
- Cost-effectiveness analysis

Class R:

- Consensus statement
- Consensus report
- Narrative review

Class X:

- Medical opinion

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses  
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Clinical Validation-Pilot Testing  
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

## Institute Partners: System-Wide Review

The guideline annotation, discussion, and measurement specification documents undergo thorough review. Written comments are solicited from clinical, measurement, and management experts from within the member groups during an eight-week review period.

Each of the Institute's participating member groups determines its own process for distributing the guideline and obtaining feedback. Clinicians are asked to suggest modifications based on their understanding of the clinical literature coupled with their clinical expertise. Representatives from all departments involved in implementation and measurement review the guideline to determine its operational impact. Measurement specifications for selected measures are developed by the Institute for Clinical Systems Improvement (ICSI) in collaboration with participating member groups following implementation of the guideline. The specifications suggest approaches to operationalizing the measure.

## Guideline Work Group

Following the completion of the review period, the guideline work group meets 1 to 2 times to review the input received. The original guideline is revised as necessary, and a written response is prepared to address each of the responses received from member groups. Two members of the Cardiovascular Steering Committee carefully review the input, the work group responses, and the revised draft of the guideline. They report to the entire committee their assessment of four questions: (1) Is there consensus among all ICSI member groups and hospitals on the content of the guideline document? (2) Has the drafting work group answered all criticisms reasonably from the member groups? (3) Within the knowledge of the appointed reviewer, is the evidence cited in the document current and not out-of-date? (4) Is the document sufficiently similar to the prior edition that a more thorough review (critical review) is not needed by the member group? The committee then either approves the guideline for release as submitted or negotiates changes with the work group representative present at the meeting.

## Pilot Test

Member groups may introduce the guideline at pilot sites, providing training to the clinical staff and incorporating it into the organization's scheduling, computer, and other practice systems. Evaluation and assessment occur throughout the pilot test phase, which usually lasts for three-six months. At the end of the pilot test phase, ICSI staff and the leader of the work group conduct an interview with the member groups participating in the pilot test phase to review their experience and gather comments, suggestions, and implementation tools.

The guideline work group meets to review the pilot sites' experiences and makes the necessary revisions to the guideline, and the Cardiovascular Steering Committee reviews the revised guideline and approves it for release.

## RECOMMENDATIONS

### MAJOR RECOMMENDATIONS

Note from the National Guideline Clearinghouse (NGC) and the Institute for Clinical Systems Improvement (ICSI): For a description of what has changed since the previous version of this guidance, refer to "[Summary of Changes Report– February 2007](#)."

The recommendations for atrial fibrillation (A Fib) are presented in the form of an algorithm with 24 components, accompanied by detailed annotations. An algorithm is provided for [Atrial Fibrillation](#); clinical highlights and selected annotations (numbered to correspond with the algorithms) follow.

Class of evidence (A-D, M, R, X) and conclusion grade (I-III, Not Assignable) definitions are repeated at the end of the "Major Recommendations" field.

### Clinical Highlights

There are five key steps in the management of patients with A Fib or atrial flutter (A Flutter) ("SALT-E"): stabilize, assess, label, treat, and educate.

After confirming the diagnosis of A Fib or A Flutter with a 12-lead electrocardiogram (ECG) (Annotation #2):

#### Stabilize

- Assess for hemodynamic instability (hypotension, myocardial ischemia, uncompensated congestive heart failure [CHF], altered medical status, or end-organ dysfunction). (Annotation #6)
- Treat hemodynamic instability with emergent direct current (DC) cardioversion and obtain an emergent cardiology or internal medicine consult. (Annotation #6)
- Establish adequate rate control. (Annotation #6)

#### Assess

- Assess thromboembolic potential and risk for bleeding. (Annotation #7)
- Hypertension is one of the primary causes and comorbidities for A Fib. Treatment for hypertension should be initiated early. (Annotation #7)
- Assess for potentially reversible causes of A Fib/A Flutter, comorbidities. (Annotation #7)

#### Label

- Label (classify) patients into 1 of three categories:
  - First Detected Episode, Duration Known  $\geq$ 48 hours or Duration Unknown
  - Recurrent A Fib
    - Paroxysmal
    - Persistent
    - Permanent
  - Recurrent A Flutter

Treatment options are determined by these three categories. (Annotation #8)



## Treat

### First Detected Episode, Duration Known $\geq$ 48 Hours or Duration Unknown

- Patients with stable A Fib or A Flutter with duration greater than 48 hours or duration unknown require appropriate anticoagulation (international normalized ratio [INR] greater than or equal to 2.0) for three weeks prior to electrical cardioversion or use of antiarrhythmics/chemical cardioversion. (Annotation #9)

### Recurrent A Fib

- Patients with paroxysmal, persistent, or permanent A Fib require assessment for chronic anticoagulation (risk of thromboembolism compared with risk of bleeding) (Annotation #12) and adequate rate control (Annotation #15)
- Patients with persistent symptoms despite adequate rate control may require intermittent cardioversion, antiarrhythmic agents, and/or electrophysiology consultation. (Annotation #20)

### Recurrent A Flutter

- Patients with recurrent A Flutter should be referred for an electrophysiology consultation. (Annotation #18C)

## Educate

Patient education is a critical component in the management of all patients with A Fib/A Flutter. Patients who have experienced one or more episodes of A Fib should be taught to periodically monitor their pulse and have a plan for treatment if they detect an irregular pulse. (Annotation #21)

## [Atrial Fibrillation Algorithm Annotations](#)

### Atrial Fibrillation/Atrial Flutter (A Fib/A Flutter) Diagnosis and Treatment

1. Patient Presentation: Signs or Physical Findings Suggestive with A Fib/A Flutter or Incidental ECG Finding

#### Key Points:

- A Fib or A Flutter can be symptomatic or asymptomatic – even in the same patient.

Symptoms or physical findings consistent with A Fib or A Flutter. A Fib or A Flutter can be symptomatic or asymptomatic – even in the same patient. Symptoms may include:

- Palpitations
- Chest pain
- Dyspnea
- Fatigue

- Lightheadedness
- Confusion
- Syncope - syncope is a rare but serious complication that usually indicates a sinus node dysfunction, an accessory atrioventricular (AV) pathway, valvular aortic stenosis, hypertrophic cardiomyopathy (HCM), or cerebrovascular disease.

Physical findings may include:

- Irregular pulse
- Heart failure
- Hypoxia
- Thromboembolism

## 2. Electrocardiogram (ECG) Confirms A Fib and/or A Flutter?

ECG is essential to the diagnosis and treatment of A Fib or A Flutter.

### ECG Characteristics of Atrial Fibrillation

A Fib is characterized by disorganized rapid atrial activity (greater than 350 beats per minute [BPM]) and may be either coarse or fine. Ventricular complexes are irregular.

### ECG Characteristics of Atrial Flutter

A Flutter is an organized reentrant rhythm, which is characterized by quite regular atrial activity (flutter or F waves) which form a saw tooth pattern that is most prominent in ECG leads II, III, and AVF. Atrial rates are typically between 240-320 BPM in the untreated state, but can slow significantly with antiarrhythmic drug therapy. Ventricular rates can be either regular or irregular. Regular rates are commonly about 150 beats per minute with a 2:1 AV block. Atypical A Flutter is also quite regular, but may differ in flutter wave morphology and rates. It is usually seen in patients who have had prior surgical atriotomies, particularly for correction of congenital heart disease.

Atrial flutter can degenerate into atrial fibrillation, A Fib can initiate A Flutter, or the ECG patterns can alternate between A Flutter and A Fib.

The distinction between atrial fibrillation and atrial flutter is particularly important in that typical atrial flutter can be easily ablated. See Annotation #20 "Consultation for Treatment Options," section on Electrophysiology Consult for more information.

### AV Node Conduction (A Fib/A Flutter)

Ventricular response to atrial fibrillation and atrial flutter depends on the ability of the AV node to conduct electrical impulses to the ventricle. AV nodal conduction is affected by intrinsic properties of the AV node, parasympathetic (vagal) inputs, sympathetic (adrenergic) inputs, drugs that depress AV nodal

conduction such as beta-blockers, calcium blockers and digoxin and drugs that may enhance conduction.

### Pre-excitation/Wolff-Parkinson-White (WPW) Syndrome

A Fib in patients with WPW syndrome is characterized on the ECG by an irregular wide complex tachycardia (pre-excited QRS complexes conducted over the accessory AV pathway). Often there may be interspersed narrow QRS complexes from beats conducted over the AV node. The ventricular response can be dangerously rapid (R-R intervals greater than 250 msec) with the potential for degeneration to ventricular fibrillation. Differential diagnosis includes ventricular tachycardia, which is usually regular when monomorphic, or polymorphic when irregular. Atrial fibrillation with bundle branch block aberrancy is also in the differential. Comparison with old ECGs should show a short PR interval with a delta wave for WPW.

Recognition of A Fib with pre-excitation is critical. The drugs commonly used to control ventricular response such as Diltiazem, Verapamil and Digoxin are ineffective and can facilitate conduction through the accessory pathway, increasing the risk for ventricular fibrillation. Direct current cardioversion is commonly the treatment of choice due to hemodynamic compromise related to rapid rates and risk of ventricular fibrillation. In less severely affected patients, rate can be controlled with intravenous (IV) Amiodarone, IV Ibutilide or IV Procainamide by depressing accessory pathway conduction. Patients should be referred to an electrophysiologist for consideration of accessory pathway ablation. Ablation removes the potential for life-threatening rapid ventricular response and may decrease the likelihood of recurrent A Fib.

### Associated Cardiac Conditions That May Influence Therapy

The electrocardiogram should also be examined for other underlying cardiac conditions, which may influence choice of therapy:

- Bundle branch block
- Left ventricular (LV) hypertrophy
- Acute myocardial infarction (MI)
- Prior acute MI
- QT prolongation
- P-wave duration and morphology or fibrillatory waves
- Other atrial arrhythmias

## 6. Stabilize Patient

### Key Points:

- Hemodynamically unstable patients represent a unique group who often have underlying structural or electrical cardiopulmonary disease.
- Hemodynamically unstable patients require hospitalization and emergent consultation from a physician with cardiology expertise, and if indicated, emergent DC cardioversion.

## Hemodynamic Stabilization

Hemodynamically unstable patients may exhibit the following symptoms:

- Hypotension
- Myocardial ischemia
- Uncompensated heart failure
- Altered mental status
- End-organ dysfunction
- Clinical deterioration

These patients represent a unique group who often have underlying structural or electrical cardiopulmonary disease including Wolff-Parkinson-White (WPW) syndrome, severe stenosis of the mitral or aortic valves, hypertrophic obstructive cardiomyopathy, cardiac tamponade/pericarditis, severe coronary artery disease or pulmonary embolism.

Additional evaluation of patients with A Fib/A Flutter presenting with hemodynamic instability may include:

- Emergent echocardiography
- Computed tomography (CT) scan of the chest, and/or
- Coronary/pulmonary angiography

Hemodynamically unstable patients require hospitalization and emergent consultation from a physician with cardiology expertise, and if indicated, emergent cardioversion.

Additional urgent treatments may include:

- Radiofrequency catheter ablation
- Internal cardioversion
- Balloon valvuloplasty
- Percutaneous transluminal coronary angioplasty (PTCA)
- Pericardiocentesis
- Septal ablation (alcohol or surgical)
- Pulmonary embolectomy
- Coronary bypass or valve replacement/repair

Anticoagulation is favored prior to and following emergent cardioversion if there are not specific contraindications, although little evidence exists. Intravenous unfractionated heparin and warfarin may be considered in:

- Patients who have been in A Fib for a few days and then develop hemodynamic instability
- Patients in whom recurrent A Fib is likely because of past experience
- Patients with mitral valve disease or left ventricular dysfunction
- Patients who following cardioversion, demonstrate spontaneous echo contrast in the left atrium or left atrial appendage

Heparin should be continued until the INR is greater than 2.0. There is little experience reported on the use of low-molecular-weight heparins following cardioversion.

For more information on anticoagulation, refer to the National Guideline Clearinghouse (NGC) summary of the Institute for Clinical Systems Improvement (ICSI) [Anticoagulation Therapy Supplement](#) guideline.

Evidence supporting this recommendation is of classes: C, R

### Acute Rate Control

Adequate rate control may help relieve symptoms including palpitations, chest pain, dyspnea, fatigue, or lightheadedness. Patients with acute MI or acute coronary symptoms require lower ventricular rates to decrease myocardial oxygen demand and limit the infarction size.

Amiodarone has become a popular antiarrhythmic choice but its use should be reserved for patients with coronary artery disease with heart failure. Patients with coronary artery disease without evidence of heart failure should be treated with Sotalol or Dofetilide first.

### Acute Rate Control Agents

Beta-blockers are the preferred agents for rate control. Beta-blockers control heart rate at rest and with exercise, and also provide cardioprotective benefits. They may be used with caution with asthma or chronic obstructive pulmonary disease (COPD). Beta-blockers are preferred for patients with A Fib and heart failure.

Calcium channel blockers are second-line rate control agents when beta-blockers are contraindicated. Calcium channel blockers control heart rate at rest and with exercise, but may exacerbate heart failure. Calcium channel blockers should not be administered in the presence of wide QRS/WPW/pre-excitation.

Concomitant use of a beta-blocker with a calcium channel blocker can, in rare circumstances, cause profound negative dromotropic, chronotropic and inotropic effects. These effects may be further exacerbated by type I or type III antiarrhythmic agents or underlying structural heart disease.

Digoxin is a third-line agent for rate control. Digoxin does not lower blood pressure and has a positive inotropic effect, but works more slowly than beta-blockers and calcium channel blockers, has no effect on the sympathetically mediated enhancement of AV node conduction during exercise, and is no better than placebo for conversion to normal sinus rhythm. Digoxin should not be administered with wide QRS/WPW/pre-excitation, hypokalemia, hypomagnesemia, and renal impairment.

Amiodarone is a first-line agent for patients with decompensated heart failure. Amiodarone has side effects including thyroid disease, hepatic

dysfunction, lung disease, neurologic dysfunction and bradycardia and should be reserved for patients with coronary artery disease with heart failure, moderate to severe systolic dysfunction, or hypertension with significant left ventricle hypertrophy.

If ventricular response remains rapid despite attempts to control rate with beta-blockers, calcium channel blockers, and/or digoxin, consultation from a physician with cardiology expertise is recommended. Treatment options include immediate cardioversion if the risk of thromboembolism is acceptable. Radiofrequency ablation of the AV node/HIS bundle followed by placement of a permanent pacemaker may be considered in medically refractory patients. It should be emphasized that the latter approach is irreversible and the patients may become pacemaker dependent. Right ventricular pacing may also induce dyssynchrony leading to future risk for developing heart failure.

Refer to the National Guideline Clearinghouse (NGC) summary of the Institute for Clinical Systems Improvement (ICSI) [Diagnosis and Treatment of Chest Pain and Acute Coronary Syndrome \(ACS\)](#) guideline for further information and discussion.

Evidence supporting this recommendation is of classes: A, R

## 7. Assess

Key Points:

- Reversible causes of A Fib/A Flutter should be sought in new arrhythmias.
- Exacerbating disease states should be evaluated and treated.

Patients presenting with a first detected episode of A Fib/A Flutter should be assessed with:

- Chest x-ray
- Echocardiogram

Patients presenting with a first detected episode of A Fib/A Flutter or with difficult rate control or with unexpected recurrence after cardioversion should also have:

- Thyroid function tests

All patients with A Fib/A Flutter should be assessed for:

- Risk Factors for Thromboembolism
- Risk Factors for Bleeding
  - History of intracranial hemorrhage or AV malformation
  - History of gastrointestinal hemorrhage
  - Severe liver disease, blood dyscrasias
  - History of medical noncompliance
  - History of frequent falls, unstable gait, or injury risk

- Age 80 or older
- Uncontrolled hypertension (greater than 180 mm Hg systolic or greater than 100 mm Hg diastolic)

In patients who are at moderate risk for bleeding, current trends favor use of anticoagulation in light of the defined benefits for anticoagulation and poorly defined criteria for bleeding risk.

For a detailed discussion of assessing risk factors for bleeding, refer to the NGC summary of the ICSI [Anticoagulation Therapy Supplement](#) guideline.

Refer to Table A in the original guideline document for information on Combined Stroke Risk Scoring (CHADS<sub>2</sub>) and Table B in the original guideline document for information on future cerebrovascular accident (CVA) risk stratification in association with A Fib using the Combined Risk Scoring (CHADS<sub>2</sub>).

All patients with A Fib/A Flutter Should Be Assessed for:

- Hypertension
- Heart failure
- Obstructive sleep apnea

Other Potentially Reversible Causes and/or Comorbidities

Cardiovascular

- Primary pulmonary hypertension
- Acute MI or unstable coronary syndrome
- AV node reentry/paroxysmal supraventricular tachycardia (PSVT)
- Accessory pathway/WPW (Wolff-Parkinson-White)
- Pericarditis/myocarditis
- Mitral valve disease/tricuspid disease
- Amyloidosis
- Congenital heart disease
- Hypertrophic cardiomyopathy

Pulmonary

- Pulmonary embolus
- Chronic obstruction pulmonary disease (COPD)
- Carbon monoxide poisoning

Metabolic

- Postoperative state/high catecholamine state
- Thyroidism

Drugs

- Alcohol

- Caffeine
- Medications including antiarrhythmic and anticholinergic
- Illicit drugs including phencyclidine (PCP) cocaine and other stimulants
- Absence of any of the risk factors listed above

Other

- Perioperative period
- Pregnancy

#### 9. First Detected Episode Duration Known $\geq$ 48 Hours or Duration Unknown

Key Points:

- Anticoagulation with warfarin (INR greater than or equal to 2.0 for three weeks) is recommended before electrical or pharmacologic cardioversion back to sinus rhythm. An alternative is transesophageal echocardiography (TEE)-guided cardioversion without the traditional pre-cardioversion anticoagulation, although this cannot be routinely recommended.
- TEE-guided cardioversion without traditional pre-cardioversion anticoagulation cannot be routinely recommended
- Amiodarone is the most effective antiarrhythmic drug for maintenance of normal sinus rhythm. However, it also is associated with the highest potential for non-cardiac toxicity, and absolutely requires regular scheduled medical follow-ups.
- Angiotensin-converting enzyme (ACE)-inhibitors and angiotensin receptor blockers (ARBs) have an emerging role as adjunctive medical therapies to antiarrhythmic drugs for maintenance of normal sinus rhythm.

#### General Recommendations

When the duration of A Fib or A Flutter is unknown, the risk of thromboembolic complications is as high as 7% following cardioversion without anticoagulation. Thus, in this setting, anticoagulation with warfarin is required (INR greater than or equal to 2.0 for three consecutive weeks). Though not a consistent clinical practice, the American College of Chest Physicians (ACCP) also recommends anticoagulation with warfarin (INR greater than or equal to 2.0 for three consecutive weeks) prior to the initiation of antiarrhythmics.

As A Fib persists for longer periods of time, the efficacy of pharmacologic cardioversion decreases. Though DC cardioversion requires conscious sedation, pharmacologic cardioversion is less effective and may cause serious arrhythmias including torsades de pointes. Antiarrhythmics like ibutilide or propafenone may be administered prior to DC cardioversion to increase the likelihood of its success.



Alternatively, the patient and/or physician may also opt for chronic anticoagulation (see Annotation #10) and chronic rate control (see Annotation #15). However, if this represents the first episode of persistent atrial fibrillation for the patient, there is general consensus that most patients deserve one trial of conversion back to normal sinus rhythm, given the high likelihood of initial success.

There is an emerging role for statin therapy following electrical cardioversion.

Evidence supporting this recommendation is of classes: A, D

### Specific Anticoagulation Issues

Whenever possible, cardioversion should be undertaken with conventional anticoagulation prior to and following cardioversion.

When anticoagulation is temporarily contraindicated (such as acute gastrointestinal [GI] bleeding), cardioversion should be delayed if possible until appropriate anticoagulation can be given prior to and following cardioversion.

When anticoagulation is contraindicated and cardioversion cannot be delayed, TEE may identify high-risk patients but may not change therapeutic decisions.

However, if TEE is used to guide anticoagulant therapy, the patient must be anticoagulated with therapeutic (not prophylactic) levels of heparin and warfarin. Heparin should be continued until the INR is greater than or equal to 2.0 for 2 consecutive days. Warfarin should be continued a minimum of four weeks following successful cardioversion.

At this time, there is insufficient evidence to recommend routine TEE to guide anticoagulant therapy prior to or following cardioversion [Conclusion Grade III: See Conclusion Grading Worksheet A - Annotation #12 (Treatment Options) in the original guideline document.]

There is little experience reported on the use of low-molecular-weight heparins prior to or following cardioversion (with or without TEE). A pilot study of TEE-guided enoxaparin plus warfarin versus TEE-guided unfractionated heparin plus warfarin (ACUTE II) is in progress. Unfortunately, this trial does not include a conventional therapy group, which is a significant omission in light of the ACUTE trial results.

For additional information on anticoagulation with warfarin, refer to the NGC summary of the ICSI [Anticoagulation Therapy Supplement](#) guideline.

Evidence supporting this recommendation is of classes: A, C, D, M, R

### DC Cardioversion

DC cardioversion has been used to treat a variety of rhythm disturbances including A Fib and A Flutter since the early 1960s. The success of external

DC cardioversion depends on patient selection and cardioversion technique. Success rates range from 65 to 95%. Success of cardioversion is increased if the left atrium is less than 60 mm (3 cm/m<sup>2</sup> body surface area [BSA]) and if the arrhythmia is of short duration.

Transthoracic cardioversion of A Fib may now be performed with biphasic waveform defibrillation. It typically uses less energy and may have greater efficacy than monophasic waveforms.

A recent study has shown that an anterior-posterior (A-P) paddle position is superior to an anterior-lateral position in success of cardioversion. The A-P position also required lower energy levels for success. If the first position is unsuccessful, paddle relocation should be considered.

Complications of DC cardioversion are uncommon but include embolization, pulmonary edema, and arrhythmias including ventricular fibrillation and asystole. DC cardioversion should be avoided in patients with known or suspected digoxin toxicity. It is unnecessary to interrupt digoxin therapy for cardioversion in patients without manifestations of toxicity.

See the original guideline document for specifics on DC cardioversion technique and information on comparing electrical and chemical cardioversion.

Evidence supporting this recommendation is of classes: A, D, R

#### Antiarrhythmic/Chemical Cardioversion

All antiarrhythmics used to treat A Fib/A Flutter can cause serious complications including the life-threatening arrhythmia torsades de pointes in up to 8% of patients. Therefore, antiarrhythmics should be initiated in the presence of a physician or nurse with expertise in the administration of antiarrhythmics with telemetry monitoring for at least 4 hours, or longer if QT remains prolonged.

Risk factors for proarrhythmia include:

- Pre-existing bradycardia or AV block
- Underlying structural heart disease
- Active heart failure or ischemia- hypokalemia or hypomagnesemia, and
- Drug dosages (e.g., lower doses for quinidine and higher doses for sotalol)

Pharmacologic therapy aimed at restoring sinus rhythm is often helpful in patients with A Fib. Conversion is much more common in patients with A Fib of less than 48 hours duration as conversion rates drop off considerably after this time.

As a general rule, regardless of the agent or route used, the conversion rate of A Fib of less than 48 hours duration is 60%-90%. Conversion rates drop to

15%-30% if present 48 hours or longer. Successful conversion of A Flutter is generally higher than for A Fib.

Agents that have been studied for conversion of A Fib to sinus rhythm include quinidine, procainamide, propafenone, flecainide, sotalol, ibutilide, and amiodarone. No single agent has emerged as the drug of choice for acute conversion of A Fib. Ibutilide is available only in the IV form and has been approved by the Food and Drug Administration (FDA) specifically for this purpose. All other agents used for acute pharmacologic conversion of A Fib are done "off-label."

Reported success rates vary in part because of the heterogeneity of patient populations— particularly with respect to the duration of A Fib in the published trials. Of the intravenous agents, only ibutilide is approved by the FDA for this indication.

Torsades de pointes (TDP) is a potentially life-threatening arrhythmia and requires prompt evaluation and treatment. See Figure 3 in the original guideline document for treatment of TDP.

Refer to Annotation #20, Table 7, "Antiarrhythmic Agents" in the original guideline document for more information on antiarrhythmic agents.

Ibutilide has been studied extensively for the conversion of recent onset A Fib and A Flutter. Efficacy rates between 30%-40% have been quoted in acute reversal of recent onset A Fib. Generally patients convert within 30 minutes. Significant adverse effect of torsades de pointes (TDP) was noted in 4.3% of patients, 1.7% requiring electrical termination. There were no deaths or severe morbidities.

Refer to Figure 2 in the original guideline document for more information on use of ibutilide.

Proarrhythmia associated with initiation of membrane antiarrhythmic agents relates to the presence of underlying structural heart disease as well as the type of drug initiated. The drugs sotalol, dofetilide, and quinidine should be initiated in all patients under telemetry guidance. These drugs should not be allowed to prolong QTc (similar to sotalol and dofetilide) to longer than 500 msec.

Amiodarone, the other class III drug, is the subject of several articles regarding its efficacy in conversion of recent onset and permanent A Fib. Amiodarone is effective in converting A Fib both acutely and chronically. It has been studied for both the oral and intravenous routes. Amiodarone can be started at maintenance doses in the outpatient setting; when high-dose loading is required or the drug is initiated in patients with structural heart disease, hospitalization should be advised. The Class I-C drugs propafenone and flecainide can also be initiated in the outpatient setting with appropriate follow-up of QRS duration that should not lengthen longer than 25%. For patients with structural heart disease, these agents should also be initiated in the inpatient setting. A new Class III agent, azimilide, may enhance future flexibility in the outpatient initiation of antiarrhythmic agents.

Oral flecainide (300 mg single dose) has similar conversion rates compared to oral propafenone (600 mg single dose) when used in patients with A Fib of acute onset (approximately 72%-78% conversion rate at eight hours).

Evidence supporting this recommendation is of classes: A, D, R

#### Failed Cardioversion Treatment Options

If initial attempts to restore normal sinus rhythm for A Fib fail, cardioversion can be repeated following a parenteral or oral loading dose of an appropriate antiarrhythmic agent. However, this approach should be avoided in patients with ejection fractions less than 30% because of the increased risk of torsades de pointes.

Furthermore, it should be noted that this is not a strategy to maintain normal sinus rhythm but only a means to enhance conversion back to sinus rhythm. Appropriate anticoagulation practices are required prior to and following cardioversion if the duration of A Fib exceeds 48 hours. If A Fib continues despite these attempts, cardiology consultation is advised.

The patient and/or physician may also opt for chronic anticoagulation and chronic rate control at this point - though the general consensus is that most patients with a first episode of A Fib or A Flutter have a high likelihood of successful conversion back to normal sinus rhythm.

Transthoracic cardioversion of A Fib may be achieved by applying biphasic waveform for defibrillation. It has been shown to be equally effective and to use less energy than monophasic waveforms.

Evidence supporting this recommendation is of class: A, R

#### Maintenance of Sinus Rhythm Following Conversion

Several antiarrhythmic drugs have been demonstrated to improve sinus rhythm maintenance following cardioversion, including amiodarone, propafenone, disopyramide, sotalol, flecainide, dofetilide, and quinidine. Amiodarone has been shown to be the single most effective agent of the lot, although it also contributes the most to noncardiac drug related toxicity. When administered at 800 mg per day for 2 weeks prior to elective cardioversion, amiodarone chemically converts one-fifth of patients with persistent AF, and when continued for 8 weeks at 200 mg per day, doubled the number of patients in normal sinus rhythm at that time. Both the ACE inhibitor, enalapril, and angiotensin receptor blocker, irbesartan, have been demonstrated to enhance the maintenance of normal sinus rhythm after cardioversion when added to amiodarone.

Evidence supporting this recommendation is of class: A

### 10. Assess Patients for Chronic Anticoagulation

Key Point:

- All patients with paroxysmal, persistent, or permanent A Fib should be assessed for chronic anticoagulation, balancing the long-term risk of thromboembolism against the long-term risk of bleeding.

Patients with either paroxysmal or persistent A Fib may benefit from anticoagulation. The long-term risk of thromboembolic complications must be balanced against the long-term risk of bleeding. The risk factors for thromboembolism and the risk factors for bleeding are detailed in Annotation #7, "Assess."

For additional information on anticoagulation, refer to the NGC summary of the ICSI [Anticoagulation Therapy Supplement](#) guideline.

Refer to Table 4 in the original guideline document for information on antithrombotic therapy depending on risk category.

#### Antiplatelet/Anticoagulant Management for Patients with Paroxysmal or Persistent Atrial Fibrillation Who Require Percutaneous Coronary Intervention

A rapidly emerging area of uncertainty is the optimal management of patients with paroxysmal or persistent atrial fibrillation who require percutaneous coronary intervention. For patients undergoing percutaneous coronary intervention, research has shown less restenosis with drug-eluting stents compared with uncoated stents. Unfortunately, recent experience has identified a prolonged risk of coronary thrombosis following implantation of drug-eluting stents. Warfarin alone does not reduce the risk of coronary thrombosis associated with stents. Aspirin and/or clopidogrel reduce the risk of thromboembolic complications associated with A Fib but are inferior to warfarin. The combination of aspirin and clopidogrel and warfarin cause more hemorrhagic complications than any one of these drugs alone.

See original guideline document for a discussion of the areas requiring further research.

Evidence supporting this recommendation is of classes: A, C, R

### 15. Assess Patient for Rate Control Agents

#### Key Point:

- Drugs that can be used for rate control of chronic A Fib include: beta-blockers, calcium blockers, and digitalis.

Beta-blockers or non-dihydropyridine calcium blockers are the initial choices for pharmacologic rate control. Beta-blockers control heart rate at rest and with exercise and also provide cardioprotective benefits. They may be used with caution with asthma or COPD. Beta-blockers are preferred for patients with A Fib and heart failure.

Calcium channel blockers are second line rate control agents when beta-blockers are contraindicated. Calcium channel blockers control heart rate at rest and with exercise but may exacerbate heart failure. Calcium channel blockers should not be administered in the presence of wide QRS/WPW/preexcitation.

Concomitant use of a beta-blocker with a calcium channel blocker can, in rare circumstances, cause profound negative dromotropic, chronotropic and inotropic effects. These effects may be further exacerbated by type I or type III antiarrhythmic agents or underlying structural heart disease.

Digoxin is a third-line agent for rate control. Digoxin can be utilized for patients with significant systolic congestive heart failure (CHF), but is inferior for exercise rate to the other agents. Digoxin does not lower blood pressure and has a positive inotropic effect, but works more slowly than beta-blockers and calcium channel blockers, has no effect on the sympathetically mediated enhancement of AV node conduction during exercise, and is no better than placebo for conversion to normal sinus rhythm. Digoxin should not be administered with wide QRS/WPW/preexcitation, hypokalemia, hypomagnesemia, and renal impairment.

Amiodarone is a first-line agent for patient with decompensated heart failure. Amiodarone has side effects including thyroid disease, hepatic dysfunction, lung disease, neurologic dysfunction and bradycardia and should be reserved for patients with coronary artery disease with heart failure, moderate to severe systolic dysfunction, or hypertension with significant left ventricle hypertrophy.

Evidence supporting this recommendation is of class: A

Refer to Table 5 in the original guideline document for more information on medications used for rate control.

## 17. Inadequate Rate Control?

Key Point:

- Adequate A Fib rate control should be assessed both at rest and exercise to eliminate symptoms and prevent the development of heart failure from tachycardia-induced cardiomyopathy.

Adequate rate control may help relieve symptoms including palpitations, chest pain, dyspnea, fatigue, or lightheadedness. Also, tachycardia-induced cardiomyopathy (TICM) is an important reversible complication of inadequate rate control. TICM can produce symptomatic congestive heart failure, thromboembolic complications, and potentially fatal ventricular arrhythmias. Thus, it is essential to maintain adequate rate control both at rest and during exercise. Patients with an acute MI or acute coronary symptoms may require lower ventricular rates to decrease myocardial oxygen demand and limit infarction size.

At rest, the heart rate should be similar to individuals in sinus rhythm less than 80-90 bpm. During exercise, the maximum rate should be no greater than the maximum set for individuals in sinus rhythm  $[0.7 \times (220 - \text{age})]$  and should not be reached during light exercise. A six-minute office walk, exercise stress test or Holter monitor (24 hour average less than 100 bpm) can assess this.

Evidence supporting this recommendation is of class: A

## 18. Inadequate Symptom Control?

Key Point:

- For the older patient over 65 years of age, rate control is an equal strategy to rhythm control for long-term management of A Fib.

Patients presenting with paroxysmal or persistent A Fib should be assessed for symptoms and for underlying cardiac disease. Restoration of sinus rhythm with cardioversion and/or suppression of A Fib with antiarrhythmic drugs are a reasonable initial strategy particularly in younger patients. Patients should be reassessed for symptoms, side effects of treatment and recurrence of A Fib with potential reconsideration of rate control strategy if appropriate. Patient with significant symptoms associated with A Fib may warrant repeated trials with antiarrhythmic drugs, possibly in combination with permanent pacing. Ablative therapies for symptomatic atrial fibrillation refractory to pharmacological management are an emerging and promising therapy.

There is no observed survival advantage to strategies aimed at restoring sinus rhythm over strategies to control rate in older patients with relatively asymptomatic atrial fibrillation based on the limited data available from studies which have compared these strategies. [Conclusion Grade II: See Conclusion Grading Worksheet B - Annotation #15 (Rhythm Versus Rate Control) in the original guideline document].

Evidence supporting this recommendation is of classes: A, R

## 20. Consultation for Treatment Options

Key Points:

- Patients with recurrent atrial fibrillation should be reassessed for symptoms during A Fib, side effects to treatment and review of past therapeutic results to plan future therapy.
- Antiarrhythmic agents used for A Fib suppression are chosen based on risk of proarrhythmia related to underlying heart disease and potential side effects. Drugs should be used in adequate doses with the reduction of the frequency and severity of symptomatic A Fib episodes as the primary treatment goal.
- Cardiac pacing may allow the use of antiarrhythmic drugs that are contraindicated due to bradycardia and also may provide definitive

rate control when coupled with His ablation in patients with poorly controlled ventricular response.

- Isthmus-dependent A Flutter can be readily controlled with radiofrequency ablation.
- Catheter-based and surgically based pulmonary vein isolation procedures show great promise in the suppression of A Fib, with better outcomes expected as techniques and experience develop.

### Intermittent Cardioversion

- Intermittent electrical or chemical cardioversion may be considered for:
  - Infrequent recurrences
  - Hemodynamic instability (see Annotation #6, "Hemodynamic Stabilization"), or
  - Failure of an antiarrhythmic agent
- Evaluate for potentially reversible causes.
- Assess for chronic anticoagulation.
- Future treatment option: implantable atrial defibrillator

### Antiarrhythmics

Antiarrhythmic agents should be individualized for the patient's anticipated proarrhythmia risks, based on underlying cardiac conditions and other comorbidities while attempting to minimize organ toxicity.

Optimal antiarrhythmic drug therapy should be effective in reducing symptoms, preventing recurrent A Fib and should have a low incidence of toxicity and proarrhythmia.

In A Fib patients without structural or organic heart disease, as demonstrated by echocardiography, exercise testing with nuclear scintigraphy or by coronary angiography, propafenone and flecainide are drugs of first choice. Low dose amiodarone and dofetilide are alternatives.

In A Fib patients with structural heart disease including coronary artery disease, but with no evidence of heart failure, sotalol and dofetilide are drugs of first choice. Amiodarone and catheter ablation are reasonable alternatives.

In A Fib patients with structural heart disease including coronary artery disease, but with evidence of heart failure, low-dose amiodarone and dofetilide are drugs of first choice.

In patients with hypertension and evidence of significant left ventricle hypertrophy, sotalol and amiodarone are drugs of choice.

Of note, low-dose amiodarone has become a popular choice but still has side effects including thyroid disease, hepatic dysfunction, lung disease, neurologic dysfunction and bradycardia. Therefore, its use should be reserved for patients with structural heart disease/coronary artery disease with heart



failure, moderate to severe systolic dysfunction and hypertension with significant left ventricle hypertrophy.

For patients with antiarrhythmic drug therapy, monitoring for side effects such as proarrhythmia, bradycardia and other systemic side effects is essential.

Refer to Table 6 in the original guideline document for additional information on selection of antiarrhythmic agent by type of condition. Refer to Table 7 in the original guideline document for dosage information of antiarrhythmic agents.

### Electrophysiology Consult

Nonpharmacologic treatment modalities for patients requiring such therapy have expanded in the last decade and include ablation, pacing, implantable defibrillation, and surgery.

Options:

- Cardiac pacing
  - Single site atrial pacing
  - Dual site atrial pacing
  - Implantable atrial defibrillator
- A Fib ablative therapies (non-atrioventricular node [AVN])
- Catheter based ablative therapies
  - HIS bundle ablation and permanent pacemaker implantation
  - Ablation for atrial flutter
  - Pulmonary vein isolation techniques
- Surgical maze procedure

Evidence supporting this recommendation is of classes: A, C, D, R

Refer to the original guideline document for more information on these options.

## 21. Monitoring for Recurrence and Patient Education

Key Points:

- Patients can monitor for recurrence of A Fib and should be given a treatment plan for managing recurrence of episodes of a Fib.
- Patient education is essential for the successful management of A Fib and A Flutter.
- Education should begin at the time of diagnosis, and should occur and be documented at every visit.
- An important part of patient education is defining expectations -- chronicity of disease, empiric treatment, and frequent recurrences despite therapy.

### Monitoring for Recurrence

- Pulse Self-Monitoring

Patients who have experienced one or more episodes of A Fib should be taught to periodically monitor their pulse. They should also be given a plan of treatment (elective vs. urgent evaluation, "pill-in-the-pocket") if they detect an irregular pulse.

- Adjunctive Monitoring

Holter monitors and event monitors may be helpful to monitor for the recurrence of A Fib in selected patients. Adjunctive monitoring is not required for all patients with a history of A Fib.

## Patient Education

Patient education is essential for the successful management of A Fib and A Flutter. Patients should be encouraged and empowered to play an active role in the self-management of their disease. Self-management is best initiated and sustained through an education partnership between the patient and the multidisciplinary health care team.

Education should begin at the time of diagnosis and should occur and be documented at every visit. A Fib in and of itself is not a life-threatening arrhythmia, provided proper anticoagulation is used to prevent thromboembolic complications.

Best patient education should include:

- Description of what A Fib/A Flutter is, including its causes
- Symptoms
- Risks associated with untreated A Fib
- Review of individual treatment plan
- Medication education
- Reason for taking medication and action
  - How to take
  - Side effects
  - Drug interactions
- How to take a pulse
- When to call the clinic:
  - Mechanism of action of warfarin: it depletes certain anticoagulation factor proteins in the blood.
  - Time of day to take warfarin: it should be taken at approximately the same time and is taken in the evening. Due to the short half-life of factor VII and its influence on the INR, this is especially important if a patient will have an INR drawn the next morning.
  - Explanation of INR, target range, and regular testing
  - Signs and symptoms of bleeding and that the provider should be contacted immediately if bleeding signs are present
  - Need to notify provider if illness, injury, or change in physical status occurs

- Need to inform all their health care providers that the patient is on anticoagulation therapy, especially if the patient is potentially undergoing an invasive procedure, surgery, or dental work

### Drug Interactions

- What to do if a new medication is initiated or a medication is discontinued, especially if the interaction with warfarin is unknown: check INR within three to four days
- Drugs that affect the absorption of warfarin
- Drugs that increase or decrease the effect of warfarin
- Common over-the-counter medication interactions including aspirin, nonsteroidal anti-inflammatory drugs (NSAIDs), acetaminophen, natural or herbal remedies, laxatives, antacids, and multivitamin preparations containing vitamin K
  - Role of vitamin K and the importance of consistency of vitamin K-rich foods in the diet rather than avoidance of vitamin K-rich foods
  - Importance of minimizing trauma risk associated with activities at high risk for injury
  - Effect of exercise: increased activity results in decreased effect of the drug
  - Effect of personal habits: alcohol, chewing tobacco, etc.
  - Effect of certain conditions: congestive heart failure, thyroid disease, gastroenteritis, and diarrhea
  - Importance of self-monitoring: maintain a log of INRs, dose of warfarin, etc.
  - Medic Alert bracelet/necklace and warfarin ID card

Refer to Appendix B, "Patient Education Guide to Warfarin Therapy," in the original guideline document for a guide to patient education regarding warfarin therapy.

Evidence supporting this recommendation is of class: R

### Definitions:

### Conclusion Grades:

Grade I: The evidence consists of results from studies of strong design for answering the question addressed. The results are both clinically important and consistent with minor exceptions at most. The results are free of any significant doubts about generalizability, bias, and flaws in research design. Studies with negative results have sufficiently large samples to have adequate statistical power.

Grade II: The evidence consists of results from studies of strong design for answering the question addressed, but there is some uncertainty attached to the conclusion because of inconsistencies among the results from the studies or because of minor doubts about generalizability, bias, research design flaws, or adequacy of sample size. Alternatively, the evidence consists solely of results

from weaker designs for the question addressed, but the results have been confirmed in separate studies and are consistent with minor exceptions at most.

Grade III: The evidence consists of results from studies of strong design for answering the question addressed, but there is substantial uncertainty attached to the conclusion because of inconsistencies among the results of different studies or because of serious doubts about generalizability, bias, research design flaws, or adequacy of sample size. Alternatively, the evidence consists solely of results from a limited number of studies of weak design for answering the question addressed.

Grade Not Assignable: There is no evidence available that directly supports or refutes the conclusion.

#### Classes of Research Reports:

##### A. Primary Reports of New Data Collection:

###### Class A:

- Randomized, controlled trial

###### Class B:

- Cohort study

###### Class C:

- Nonrandomized trial with concurrent or historical controls
- Case-control study
- Study of sensitivity and specificity of a diagnostic test
- Population-based descriptive study

###### Class D:

- Cross-sectional study
- Case series
- Case report

##### B. Reports that Synthesize or Reflect upon Collections of Primary Reports:

###### Class M:

- Meta-analysis
- Systematic review
- Decision analysis
- Cost-effectiveness analysis

###### Class R:

- Consensus statement

- Consensus report
- Narrative review

Class X:

- Medical opinion

## CLINICAL ALGORITHM(S)

A detailed and annotated clinical algorithm is provided for [Atrial Fibrillation](#).

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is classified for selected recommendations (see "Major Recommendations").

In addition, key conclusions contained in the Work Group's algorithm are supported by a grading worksheet that summarizes the important studies pertaining to the conclusion. The type and quality of the evidence supporting these key recommendations (i.e., choice among alternative therapeutic approaches) is graded for each study.

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

- Improved rate control in patients with permanent A Fib
- Increased percentage of patients age 18 years and older who are accurately diagnosed with A Fib
- Improved consistency of anticoagulation in patients with paroxysmal, persistent, or permanent A Fib/Flutter.
- Increased percentage of patients with A Fib who receive patient education

### POTENTIAL HARMS

All antiarrhythmics used to convert atrial fibrillation (A Fib)/atrial flutter (A Flutter) to sinus rhythm can cause serious complications, including life-threatening torsades de pointes (TDP) in up to 8% of patients.

Risk factors for proarrhythmia include:

- Preexisting bradycardia or atrioventricular block
- Underlying structural heart disease
- Active congestive heart failure (CHF) or ischemia-hypokalemia or hypomagnesemia
- Drug doses (e.g., lower doses for quinidine and higher doses for sotalol)

Side effects for rate control agents include:

- Beta-blockers may cause or worsen bronchospasm in patients with asthma or chronic obstructive pulmonary disease (COPD).
- Beta-blockers, calcium channel blockers, and digoxin should not be administered to patients with wide QRS/Wolff-Parkinson-White (WPW)/preexcitation. These drugs can cause accelerated conduction over the bypass tract with the risk of deteriorating to ventricular fibrillation.
- Concomitant use of a beta-blocker with a calcium channel blocker can, in rare circumstances, cause profound negative dromotropic, chronotropic, and inotropic effects. These effects may be further exacerbated by type I or type III antiarrhythmic agents or underlying structural heart disease.
- When administering any rate control agent, caution must be taken if there is any evidence of sick sinus syndrome, other conduction system disease, or structural heart disease.

Other potential adverse reactions and interactions to rate control and antiarrhythmic medications are outline in Tables 5 and 7 of the original guideline document.

- Anticoagulant medication: Bleeding is the major side effect. The combination of aspirin and clopidogrel and warfarin cause more hemorrhagic complications than any one of these drugs alone. For more information, see Appendix A, "Risk Factors for Bleeding during Warfarin Therapy", in the original guideline document and the National Guideline Clearinghouse (NGC) summary of the Institute for Clinical Systems Improvement (ICSI) [Anticoagulation Therapy Supplement](#) guideline.
- Recent experience has identified a prolonged risk of coronary thrombosis following implantation of drug-eluting stents.
- Complications of electrical direct current (DC) cardioversion include embolization and, more rarely, pulmonary edema and arrhythmias including ventricular fibrillation and asystole. DC cardioversion should be avoided in patients with known or suspected digoxin toxicity.
- Placement of a permanent pacemaker is irreversible and the patient may become pacemaker dependent.

## CONTRAINDICATIONS

### CONTRAINDICATIONS

Contraindications to chemical cardioversion include:

- Hemodynamic instability
- Acute coronary ischemia
- Marked bradycardia, digoxin toxicity
- QTc<sub>460</sub> msec or more
- Marked left ventricular hypertrophy
- Marked left ventricular failure
- Hypokalemia
- Hypomagnesemia
- Currently on an antiarrhythmic

Relative contraindications to chemical cardioversion include:

Duration greater than one month

Relative contraindications to direct current (DC) cardioversion include:

- Fresh chest wound
- Fear of DC cardioversion

## QUALIFYING STATEMENTS

### QUALIFYING STATEMENTS

- These clinical guidelines are designed to assist clinicians by providing an analytical framework for the evaluation and treatment of patients, and are not intended either to replace a clinician's judgment or to establish a protocol for all patients with a particular condition. A guideline will rarely establish the only approach to a problem.
- This clinical guideline should not be construed as medical advice or medical opinion related to any specific facts or circumstances. Patients are urged to consult a health care professional regarding their own situation and any specific medical questions they may have.
- This document is not intended to replace the comprehensive guideline, American College of Cardiology (ACC)/American Heart Association (AHA)/European Society of Cardiology (ESC) 2006 Guidelines for the Management of Patients with Atrial Fibrillation, which the interested provider is encouraged to review.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

Once a guideline is approved for release, a member group can choose to concentrate on the implementation of that guideline. When four or more groups choose the same guideline to implement and they wish to collaborate with others, they may form an action group.

In the action group, each medical group sets specific goals they plan to achieve in improving patient care based on the particular guideline(s). Each medical group shares its experiences and supporting measurement results within the action group. This sharing facilitates a collaborative learning environment. Action group learnings are also documented and shared with interested medical groups within the collaborative.

Currently, action groups may focus on one guideline or a set of guidelines such as hypertension, lipid treatment, and tobacco cessation.

Detailed measurement strategies are presented in the original guideline document to help close the gap between clinical practice and the guideline recommendations. Summaries of the measures are provided in the National Quality Measures Clearinghouse (NQMC).

## Key Implementation Recommendations

The following system changes were identified by the guideline work group as key strategies for health care systems to incorporate in support of the implementation of this guideline.

1. Develop a process for alerting physicians that an electrocardiogram has confirmed a diagnosis of Atrial Fibrillation/Flutter.
2. Develop a process for implementing the five key steps in the management of Atrial Fibrillation/Flutter ("SALT-E"):
  - Stabilize
  - Assess
  - Label
  - Treat
  - Educate

## IMPLEMENTATION TOOLS

Clinical Algorithm  
Patient Resources  
Pocket Guide/Reference Cards  
Quality Measures

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

## RELATED NQMC MEASURES

- [Atrial fibrillation: percentage of patients \(without contraindications to anticoagulation\) with paroxysmal, persistent, or permanent atrial fibrillation/atrial flutter \(A Fib/Flutter\) with risk factors for thromboembolism who are on warfarin.](#)

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Getting Better  
Living with Illness

### IOM DOMAIN

Effectiveness  
Patient-centeredness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)



Institute for Clinical Systems Improvement (ICSI). Atrial fibrillation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2007 Feb. 64 p. [112 references]

#### ADAPTATION

Not applicable: The guideline was not adapted from another source.

#### DATE RELEASED

2000 Oct (revised 2007 Feb)

#### GUIDELINE DEVELOPER(S)

Institute for Clinical Systems Improvement - Private Nonprofit Organization

#### GUIDELINE DEVELOPER COMMENT

Organizations participating in the Institute for Clinical Systems Improvement (ICSI): Affiliated Community Medical Centers, Allina Medical Clinic, Altru Health System, Aspen Medical Group, Avera Health, CentraCare, Columbia Park Medical Group, Community-University Health Care Center, Dakota Clinic, ENT Specialty Care, Fairview Health Services, Family HealthServices Minnesota, Family Practice Medical Center, Gateway Family Health Clinic, Gillette Children's Specialty Healthcare, Grand Itasca Clinic and Hospital, HealthEast Care System, HealthPartners Central Minnesota Clinics, HealthPartners Medical Group and Clinics, Hutchinson Area Health Care, Hutchinson Medical Center, Lakeview Clinic, Mayo Clinic, Mercy Hospital and Health Care Center, MeritCare, Mille Lacs Health System, Minnesota Gastroenterology, Montevideo Clinic, North Clinic, North Memorial Care System, North Suburban Family Physicians, Northwest Family Physicians, Olmsted Medical Center, Park Nicollet Health Services, Pilot City Health Center, Quello Clinic, Ridgeview Medical Center, River Falls Medical Clinic, Saint Mary's/Duluth Clinic Health System, St. Paul Heart Clinic, Sioux Valley Hospitals and Health System, Southside Community Health Services, Stillwater Medical Group, SuperiorHealth Medical Group, University of Minnesota Physicians, Winona Clinic, Ltd., Winona Health

ICSI, 8009 34th Avenue South, Suite 1200, Bloomington, MN 55425; telephone, (952) 814-7060; fax, (952) 858-9675; e-mail: [icsi.info@icsi.org](mailto:icsi.info@icsi.org); Web site: [www.icsi.org](http://www.icsi.org).

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#### GUIDELINE COMMITTEE

Cardiovascular Steering Committee

## COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Work Group Members: Thomas Munger, MD (Work Group Leader) (Mayo Clinic) (Cardiology/Electrophysiology); David Dunbar, MD (St. Paul Heart Clinic) (Cardiology/Electrophysiology); David Handley, MD (Olmsted Medical Center) (Emergency Medicine); Tim Donelan, MD (Sioux Valley Hospitals and Health System) (Family Medicine); Brad Hruby, MD (Sioux Valley Hospitals and Health System) (Family Medicine); Joseph Van Kirk, MD (Lakeview Clinic) (Family Medicine); Sai Haranath, MD (MeritCare) (Internal Medicine); Mark Morrow, MD (Aspen Medical Group) (Internal Medicine); Peter Marshall, PharmD (HealthPartners Health Plan) (Pharmacy); Shelly Bartsch, CNS (Park Nicollet Health Services) (Nursing); Penny Fredrickson (Institute for Clinical Systems Improvement) (Measurement Advisor); Sherri Huber, MT (ASCP) (Institute for Clinical Systems Improvement) (Facilitator)

## FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

In the interest of full disclosure, ICSI has adopted the policy of revealing relationships work group members have with companies that sell products or services that are relevant to this guideline topic. The reader should not assume that these financial interests will have an adverse impact on the content of the guideline, but they are noted here to fully inform readers. Readers of the guideline may assume that only work group members listed below have potential conflicts of interest to disclose.

Thomas Munger, MD receives research from Raiter.

No other work group members have potential conflicts of interest to disclose.

ICSI's conflict of interest policy and procedures are available for review on ICSI's website at [www.icsi.org](http://www.icsi.org).

## GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Atrial fibrillation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2004 Nov. 60 p.

## GUIDELINE AVAILABILITY

Electronic copies: Available from the [Institute for Clinical Systems Improvement \(ICSI\) Web site](http://www.icsi.org).

Print copies: Available from ICSI, 8009 34th Avenue South, Suite 1200, Bloomington, MN 55425; telephone, (952) 814-7060; fax, (952) 858-9675; Web site: [www.icsi.org](http://www.icsi.org); e-mail: [icsi.info@icsi.org](mailto:icsi.info@icsi.org).

## AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Atrial fibrillation. Executive summary. Bloomington (MN): Institute for Clinical Systems Improvement, 2007 Feb. 2 p. Electronic copies: Available from the [Institute for Clinical Systems Improvement \(ICSI\) Web site](#).
- ICSI pocket guidelines. April 2006 edition. Bloomington (MN): Institute for Clinical Systems Improvement, 2006. 298 p.

Print copies: Available from ICSI, 8009 34th Avenue South, Suite 1200, Bloomington, MN 55425; telephone, (952) 814-7060; fax, (952) 858-9675; Web site: [www.icsi.org](http://www.icsi.org); e-mail: [icsi.info@icsi.org](mailto:icsi.info@icsi.org).

## PATIENT RESOURCES

Appendix B of the [original guideline document](#) includes a patient education guide to warfarin therapy.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

## NGC STATUS

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